

OFFICIAL ICD-9-CM GUIDELINES FOR CODING AND REPORTING

The Public Health Service and the Health Care Financing Administration of the U.S. Department of Health and Human Services present the following guidelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). These guidelines should be used as a companion document to the official versions of the ICD-9-CM.

These guidelines for coding and reporting have been developed and approved by the cooperating parties for ICD-9-CM: American Hospital Association, American Health Information Management Association, Health Care Financing Administration and the National Center for Health Statistics. These guidelines previously appeared in the Coding Clinic for ICD-9-CM, published by the American Hospital Association.

These guidelines have been developed to assist the user in coding and reporting in situations where the ICD-9-CM manual does not provide direction. Coding and sequencing instructions in the three ICD-9-CM manuals take precedence over any guidelines.

These guidelines are not exhaustive. The cooperating parties are continuing to conduct review of these guidelines and develop new guidelines as needed. Users of the ICD-9-CM should be aware that only guidelines approved by the cooperating parties are official. Revision of these guidelines and new guidelines will be published by the U.S. Department of Health and Human Services when they are approved by the cooperating parties.

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TABLE OF CONTENTS

Adverse Effects and Poisoning	9
Adverse Effect	9.1
Poisoning	9.2
Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-Based and Physician Office)	12
External Causes of Diseases and Injuries	11
Child and Adult Abuse	11.5
General Coding guidelines	11.1
Late effects	11.8
Misadventures and complications of care	11.9
Multiple external causes	11.4
Place of occurrence	11.2
Poisonings and adverse effects of drugs	11.3
Undetermined cause	11.7
Unknown intent	11.6
General Inpatient Coding Guidelines	1
Acute and Chronic Conditions	1.4; 2.3
Combination Code	1.5
Impending or Threatened Condition	1.9

Late Effect	1.7
Level of Specificity in Coding	1.2
Multiple Coding of Diagnoses	1.6
Other and Unspecified (NOS) Code Titles	1.3
Uncertain Diagnosis	1.8
Use of Alphabetic Index and Tabular List	1.1
Human Immunodeficiency Virus (HIV) Infections	10
Asymptomatic HIV Infection	10.6
Confirmed Cases of HIV Infection/Illness	10.1
HIV Infection in Pregnancy, Childbirth and the Puerperium	10.5
Inconclusive Lab Test for HIV	10.7
Previously Diagnoses HIV-related Illness	10.3
Selection of HIV Code	10.2
Sequencing	10.4
Testing for HIV	10.8
Hypertension	4
Controlled Hypertension	4.9
Elevated Blood Pressure	4.11
Essential Hypertension	4.1
Hypertension with Heart Disease	4.2
Hypertensive Cardiovascular Disease	4.5
Hypertensive Heart and Renal Disease	4.4
Hypertensive Renal Disease with Chronic Renal Failure	4.3
Hypertensive Retinopathy	4.6
Secondary Hypertension	4.7
Transient Hypertension	4.8
Uncontrolled Hypertension	4.10
Newborn Coding	6
Category V29	6.3
Congenital Anomalies	6.5
Maternal Causes of Perinatal Morbidity	6.4
Newborn Transfers	6.2
Other (Additional) Diagnoses	6.6
Prematurity and Fetal Growth Retardation	6.7
Use of Codes V30-V39	6.1
Obstetrics	5
General Rules	5.1
Selection of Principal Diagnosis	5.2
Chapter 11 Fifth-digits	5.3
Fetal Conditions Affecting Management of Mother	5.4
Normal Delivery 650	5.5
Procedure Codes	5.6
Postpartum Period	5.7
Abortions	5.8

Late Effects of Complications of Pregnancy, Childbirth and the Puerperium	5.9
Reporting Other (Additional) Diagnoses	3
Abnormal Findings	3.5
Conditions Integral to a Disease Process	3.3
Conditions Not Integral to a Disease Process	3.4
Diagnoses Not Listed in Final Diagnostic Statement	3.2
Previous Conditions	3.1
Selection of Principal Diagnosis	2
Acute and Chronic Conditions	2.3; 1.4
Codes from V71.0-V71.9, Observation and Evaluation for Suspected Conditions, not found	2.8
Complications of Pregnancy	2.16
Complications of Surgery and Other Medical Care	2.15
Codes in Brackets in the Alphabetic Index	2.2
Multiple Burns	2.11; 8.3
Multiple Injuries	2.12
Neoplasms	2.13
Original Treatment Plan Not Carried Out	2.9
Poisoning	2.14
Residual Condition or Nature of Late Effect	2.10
Symptoms, Signs, and Ill-defined Conditions	2.1
Symptom Followed by Contrasting/Comparative Diagnoses	2.7
Two or More Interrelated Conditions	2.4
Two or More Equally Meet Definition	2.5
Two or More Comparative or Contrasting Conditions	2.6
Septicemia and Shock	7
Trauma	8
Current Burns and Encounters for Late Effects of Burns	8.3
Debridement of Wound, Infection or Burn	8.4
Multiple Fractures	8.2
Multiple Injuries	8.1

1. GENERAL INPATIENT CODING GUIDELINES

1.1 Use of Both Alphabetic Index and Tabular List

- A. Use both the Alphabetic Index and the Tabular List when locating and assigning a code. Reliance on only the Alphabetic Index or the Tabular List leads to errors in code assignments and less specificity in code selection.
- B. Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

1.2 Level of Specificity in Coding

Diagnostic and procedure codes are to be used at their highest level of specificity:

Assign three-digit codes only if there are no four-digit codes within that code category.

Assign four-digit codes only if there is no fifth-digit subclassification for that category.

Assign the fifth-digit subclassification code for those categories where it exists.

1.3 Other (NEC) and Unspecified (NOS) Code Titles

Codes labeled "other specified" (NEC; not elsewhere classified) or "unspecified" (NOS; not otherwise specified) are used only when neither the diagnostic statement nor a thorough review of the medical record provides adequate information to permit assignment of a more specific code.

Use the code assignment for "other" or NEC when the information at hand specifies a condition but no separate code for that condition is provided.

Use "unspecified" (NOS) when the information at hand does not permit either a more specific or "other" code assignment.

When the Alphabetic Index assigns a code to a category labeled "other (NEC)" or to a category labeled "unspecified (NOS)", refer to the Tabular List and review the titles and inclusion terms in the subdivisions under that particular three-digit category (or subdivision under the four-digit code) to determine if the information at hand can be appropriately assigned to a more specific code.

1.4 Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

1.5 Combination Code

A single code used to classify two diagnoses or a diagnosis with an associated secondary process (manifestation) or an associated complication is called a combination code. Combination codes are identified by referring to subterm entries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

- A. Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs. Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code may be used as a secondary code.

1.6 Multiple Coding of Diagnoses

Multiple coding is required for certain conditions not subject to the rules for combination codes.

Instruction for conditions that require multiple coding appear in the Alphabetic Index and the Tabular List.

- A. Alphabetic Index: Codes for both etiology and manifestation of a disease appear following the subentry term, with the second code in brackets. Assign both codes in the same sequence in which they appear in the Alphabetic Index.
- B. Tabular List: Instructional terms, such as "Code first...", "Use additional code for any...", and "Note...", indicate when to use more than one code.
 - "Code first underlying disease" - Assign the codes for both the manifestation and underlying cause. The codes for manifestations cannot be used (designated) as principal diagnosis.
 - "Use additional code, to identify manifestation, as ..." - Assign also the code that identifies the manifestation, such as, but not limited to, the examples listed. The codes for manifestations cannot be used (designated) as principal diagnosis.
- C. Apply multiple coding instructions throughout the classification where appropriate, whether or not multiple coding directions appear in the Alphabetic Index or the Tabular List. Avoid indiscriminate multiple coding or irrelevant information, such as symptoms or signs characteristic of the diagnosis.

1.7 Late Effect

A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a

previous injury.

Coding of late effects requires two codes:

The residual condition or nature of the late effect

The cause of the late effect

The residual condition or nature of the late effect is sequenced first, followed by the cause of the late effect, except in those few instances where the code for late effect is followed by a manifestation code identified in the Tabular List and title or the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s).

The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the cause of the late effect.

A. Late Effects of Cerebrovascular Disease

Category 438 is used to indicate conditions classifiable to categories 430-437 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to 430-437. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to 430-437.

Codes from category 438 may be assigned on a health care record with codes from 430-437, if the patient has a current CVA and deficits from an old CVA.

Assign code V12.59 (and not a code from category 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

1.8 Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", code the condition as if it existed or was established. The bases for this guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

1.9 Impending or Threatened Condition

Code any condition described at the time of discharge as "impending" or "threatened" as follows:

If it did occur, code as confirmed diagnosis.

If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for "impending" or "threatened" and also reference main term entries for Impending and for Threatened.

If the subterms are listed, assign the given code.

If the subterms are not listed, code the existing forerunner condition(s) and not the condition described as impending or threatened.

2. SELECTION OF PRINCIPAL DIAGNOSIS

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care".

In determining principal diagnosis the coding directives in the ICD-9-CM manuals, Volumes I, II, and III, take precedence over all other guidelines.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

2.1 Codes for symptoms, signs, and ill-defined conditions.

Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

2.2 Codes in brackets.

Codes in brackets in the Alphabetic Index can never be sequenced as principal diagnosis. Coding directives require that the codes in brackets be sequenced in the order as they appear in the Alphabetic Index.

2.3 Acute and chronic conditions.

If the same condition is described as both acute (subacute) and chronic and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

2.4 Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.

When there are two or more interrelated conditions (such as diseases in the same ICD-9-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

2.5 Two or more diagnoses that equally meet the definition for principal diagnosis.

In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

2.6 Two or more comparative or contrasting conditions.

In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

2.7 A symptom(s) followed by contrasting/comparative diagnoses.

When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as suspected conditions.

2.8 Codes from the V71.0-V71.9 series, Observation and evaluation for suspected conditions.

Codes from the V71.0-V71.9 series are assigned as principal diagnoses for encounters or admissions to evaluate the patient's condition when there is some evidence to suggest the existence of an abnormal condition or following an accident or other incident that ordinarily results in a health problem, and where no supporting evidence for the suspected condition is found and no treatment is

currently required. The fact that the patient may be scheduled for continuing observation in the office/clinic setting following discharge does not limit the use of this category.

2.9 Original treatment plan not carried out.

Sequence as the principal diagnosis the condition which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

2.10 Residual condition or nature of late effect.

The residual condition or nature of the late effect is sequenced first, followed by the late effect code for the cause of the residual condition, except in a few instances where the Alphabetic Index or Tabular List directs otherwise.

2.11 Multiple burns.

Sequence first the code that reflects the highest degree of burn when more than one burn is present. (See also Burns guideline 8.3)

2.12 Multiple injuries.

When multiple injuries exist, the code for the most severe injury as determined by the attending physician is sequenced first.

2.13 Neoplasms.

- A. If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis, except when the purpose of the encounter or hospital admission is for radiotherapy session(s), V58.0, or for chemotherapy session(s), V58.1, in which instance the malignancy is coded and sequenced second.
- B. When a patient is admitted for the purpose of radiotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal diagnosis is Encounter for radiotherapy, V58.0, or Encounter for chemotherapy, V58.1.
- C. When an episode of inpatient care involves surgical removal of a primary site or secondary site malignancy followed by adjunct chemotherapy or radiotherapy, code the malignancy as the principal diagnosis, using codes in the 140-198 series or where appropriate in the 200-203 series.

- D. When the reason for admission is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal diagnosis, even though chemotherapy or radiotherapy is administered.
- E. When the primary malignancy has been previously excised or eradicated from its site and there is not adjunct treatment directed to that site and no evidence of any remaining malignancy at the primary site, use the appropriate code from the V10 series to indicate the former site of primary malignancy. Any mention of extension, invasion, or metastasis to a nearby structure or organ or to a distant site is coded as a secondary malignant neoplasm to that site and may be the principal diagnosis in the absence of the primary site.
- F. When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.
- G. Symptoms, signs, and ill-defined conditions listed in Chapter 16 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.
- H. Coding and sequencing of complications associated with the malignant neoplasm or with the therapy thereof are subject to the following guidelines:

When admission is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the anemia is designated at the principal diagnosis and is followed by the appropriate code(s) for the malignancy.

When the admission is for management of an anemia associated with chemotherapy or radiotherapy and the only treatment is for the anemia, the anemia is designated as the principal diagnosis followed by the appropriate code(s) for the malignancy.

When the admission is for management of dehydration due to the malignancy or the therapy, or a combination of both, and only the dehydration is being treated (intravenous rehydration), the dehydration is designated as the principal diagnosis, followed by the code(s) for the malignancy.

When the admission is for treatment of a complication resulting from a surgical procedure performed for the treatment of an intestinal malignancy, designate the complication as the principal diagnosis if treatment is directed at resolving the complication.

2.14 Poisoning

When coding a poisoning or reaction to the improper use of a medication (e.g., wrong dose, wrong substance, wrong route of administration) the poisoning code is sequenced first, followed by a code for the manifestation. If there is also a diagnosis of drug abuse or dependence to the substance, the abuse or dependence is coded as an additional code.

2.15 Complications of surgery and other medical care.

When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the 996-999 series, an additional code for the specific complication may be assigned.

2.16 Complication of pregnancy.

When a patient is admitted because of a condition that is either a complication pregnancy or that is complicating the pregnancy, the code for the obstetric complication is the principal diagnosis. An additional code may be assigned as needed to provide specificity.

3. REPORTING OTHER (ADDITIONAL) DIAGNOSES

A joint effort between the attending physician and coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

These guidelines have been developed and approved by the Cooperating Parties to assure both the physician and the coder in identifying those diagnoses that are to be reported in addition to the principal diagnosis. Hospitals may record other diagnoses as needed for internal data use.

The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No. 147), pp. 31038-40.

The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded".

GENERAL RULE

For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

The following guidelines are to be applied in designating "other diagnoses" when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provide direction.

The listing of the diagnoses on the attestation statement is the responsibility of the attending physician.

3.1 Previous conditions.

If the physician has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some physicians include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

3.2 Diagnoses not listed in the final diagnostic statement.

When the physician has documented what appears to be a current diagnosis in the body of the record, but has not included the diagnosis in the final diagnostic statement, the physician should be asked whether the diagnosis should be added.

3.3 Conditions that are an integral part of a disease process.

Conditions that are integral to the disease process should not be assigned as additional codes.

3.4 Conditions that are not an integral part of a disease process.

Additional conditions that may not be associated routinely with a disease process should be coded when present.

3.5 Abnormal findings.

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the diagnosis should be added.

4. HYPERTENSION

4.1 Hypertension, Essential, or NOS

Assign hypertension (arterial) (essential) (primary) (systemic) (NOS) to category code 401 with the appropriate fourth digit to indicate malignant (.0), benign (.1), or unspecified (.9). Do not use either .0 malignant or .1 benign unless medical record documentation supports such a designation.

4.2 Hypertension with Heart Disease

Certain heart conditions (425.8, 428, 429.0-429.3, 429.8, 429.9) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use only the code from category 402.

The same heart conditions (425.8, 428, 429.0-429.3, 429.8, 429.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission.

4.3 Hypertensive Renal Disease with Chronic Renal Failure

Assign codes from category 403, Hypertensive renal disease, when conditions classified to categories 585-587 are present. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies renal failure with hypertension as hypertensive renal disease.

4.4 Hypertensive Heart and Renal Disease

Assign codes from combination category 404, Hypertensive heart and renal disease, when both hypertensive renal disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the renal disease, whether or not the condition is so designated.

4.5 Hypertensive Cerebrovascular Disease.

First assign codes from 430-438, Cerebrovascular disease, then the appropriate hypertension code from categories 401-405.

4.6 Hypertensive Retinopathy

Two codes are necessary to identify the condition. First assign the code from subcategory 362.11, Hypertensive retinopathy, then the appropriate code from categories 401-405 to indicate the type of hypertension.

4.7 Hypertension, Secondary

Two codes are required: one to identify the underlying condition and one from category 405 to identify the hypertension. Sequencing of codes is determined by the reason for admission to the hospital.

4.8 Hypertension, Transient

Assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code 642.3x for transient hypertension of pregnancy.

4.9 Hypertension, Controlled

Assign appropriate code from categories 401-405. This diagnostic statement usually refers to an existing state of hypertension under control by therapy.

4.10 Hypertension, Uncontrolled

Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories 401-405 to designate the stage and type of hypertension. Code to the type of hypertension.

4.11 Elevated Blood Pressure

For a statement of elevated blood pressure without further specificity, assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, rather than a code from category 401.

5. OBSTETRICS

Introduction

These guidelines have been developed and approved by the Cooperating Parties in conjunction with the Editorial Advisory Board of Coding Clinic and the American College of Obstetricians and Gynecologists, to assist the coder in coding and reporting obstetric cases. Where feasible, previously published advice has been incorporated. Some advice in these new guidelines may supersede previous advice. The guidelines are provided for

reporting purposes. Health care facilities may record additional diagnoses as needed for internal data needs.

5.1 General Rules

- A. Obstetric cases require codes from chapter 11, codes in the range 630-677, Complications of Pregnancy, Childbirth, and the Puerperium. Should the physician document that the pregnancy is incidental to the encounter than code V22.2 should be used in place of any chapter 11 codes. It is the physician's responsibility to state that the condition being treated is not affecting the pregnancy.
- B. Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions.
- C. Chapter 11 codes are to be used only on the maternal record, never on the record of the newborn.
- D. An outcome of delivery code, V27.0-V27.9, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.

5.2 Selection of Principal Diagnosis

- A. The circumstances of the encounter govern the selection of the principal diagnosis.
- B. In episodes when no delivery occurs the principal diagnosis should correspond to the principal complication of the pregnancy which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complications codes may be sequenced first.
- C. When a delivery occurs the principal diagnosis should correspond to the main circumstances or complication of the delivery. In cases of cesarean deliveries, the principal diagnosis should correspond to the reason the cesarean was performed, unless the reason for admission was unrelated to the condition resulting in the cesarean delivery.
- D. For routine prenatal visits when no complications are present codes V22.0, Supervision of normal first pregnancy, and V22.1, Supervision of other normal pregnancy, should be used as principal diagnoses. These codes should not be used in conjunction with chapter 11 codes.

- E. For prenatal outpatient visits for patients with high-risk pregnancies, a code from category V23, Supervision of high-risk pregnancy, should be used as the principal diagnosis. Secondary chapter 11 codes may be used in conjunction with these codes if appropriate. A thorough review of any pertinent excludes note is necessary to be certain that these V codes are being used properly.

5.3 Chapter 11 Fifth-digits

- A. Categories 640-648, 651-676 have required fifth-digits which indicate whether the encounter is antepartum, postpartum and whether a delivery has also occurred.
- B. The fifth-digits which are appropriate for each code number are listed in brackets under each code. The fifth-digits on each code should all be consistent with each other. That is, should a delivery occur all of the fifth-digits should indicate the delivery.

5.4 Fetal Conditions Affecting the Management of the Mother.

Codes from category 655, Known or suspected fetal abnormality affecting management of the mother, and category 656, Other fetal and placental problems affecting the management of the mother, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

5.5 Normal Delivery, 650

- A. Code 650 is for use in cases when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode.
- B. 650 may be used if the patient had a complications at some point during her pregnancy but the complication is not present at the time of the admission for delivery.
- C. Code 650 is always a principal diagnosis. It is not to be used if any other code from chapter 11 is needed to describe a current complication of the antenatal, delivery, or perinatal period. Additional codes from other chapters may be used with code 650 if they are not related to or are in any way complicating the pregnancy.
- D. V27.0, Single liveborn, is the only outcome of delivery code appropriate for use with 650.

5.6 Procedure Codes

- A. In cases of cesarean delivery, the selection of the principal diagnosis should correspond to the reason the cesarean delivery was performed unless the

reason for admission was unrelated to the condition resulting in the cesarean delivery.

- B. A delivery procedure code should not be used for a woman who has delivered prior to admission to the hospital. Any postpartum repairs should be coded.

5.7 The Postpartum Period

- A. The postpartum period begins immediately after delivery and continues for 6 weeks following delivery.
- B. A postpartum complication is any complication occurring within the 6 week period.
- C. Chapter 11 codes may also be used to describe pregnancy-related complications after the 6 week period should the physician document that a condition is pregnancy related.
- D. Postpartum complications that occur during the same admission as the delivery are identified with a fifth digit of "2". Subsequent admissions for postpartum complications should be identified with a fifth digit of "4".
- E. When the mother delivers outside the hospital prior to admission and is admitted for routine postpartum care and no complications are noted, code V24.0, Postpartum care and examination immediately after delivery, should be assigned as the principal diagnosis.

5.8 Abortions

- A. Fifth-digits are required for abortion categories 634-637. Fifth-digit 1, incomplete, indicates that all of the products of conception have not been expelled from the uterus. Fifth-digit 2, complete, indicates that all products of conception have been expelled from the uterus prior to the episode of care.
- B. A code from categories 640-648 and 651-657 may be used as additional codes with an abortion code to indicate the complication leading to the abortion.

Fifth digit 3 is assigned with codes from these categories when used with an abortion code because the other fifth digits will not apply. Codes from the 660-669 series are not to be used for complications of abortion.

- C. Code 639 is to be used for all complications following abortion. Code 639 cannot be assigned with codes from categories 634- 638.
- D. Abortion with Liveborn Fetus. When an attempted termination of pregnancy results in a liveborn fetus assign code 644.21, Early onset of delivery, with an appropriate code from category V27, Outcome of Delivery. The procedure code for the attempted termination of pregnancy should also be assigned.
- E. Retained Products of Conception following an abortion. Subsequent admissions for retained products of conception following a spontaneous or legally induced abortion are assigned the appropriate code from category 634, Spontaneous abortion, or legally induced abortion, with a fifth digit of "01" (incomplete). This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion.

5.9 Code 677, Late effect of complication of pregnancy, childbirth, and the puerperium

- A. Code 677, Late effect of complication of pregnancy, childbirth, and the puerperium is for use in those cases when an initial complication of a pregnancy develops a sequelae requiring care or treatment at a future date.
- B. This code may be used at any time after the initial postpartum period.
- C. This code, like all late effect codes, is to be sequenced following the code describing the sequelae of the complication.

6. NEWBORN GUIDELINES

Definition

The newborn period is defined as beginning at birth and lasting through the 28th day following birth.

The following guidelines are provided for reporting purposes. Hospitals may record other diagnoses as needed for internal data use.

GENERAL RULE

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or

extended length of hospital stay; or
increased nursing care and/or monitoring; or
has implications for future health care needs.

Note: The newborn guidelines listed above are the same as the general coding guidelines for "other diagnoses," except for the final bullet regarding implications for future health care needs. Whether or not a condition is clinically significant can only be determined by the physician.

6.1 Use of Codes V30-V 39

When coding the birth of an infant, assign a code from categories V30-V39, according to the type of birth. A code from this series is assigned as a principal diagnosis, and assigned only once to a newborn at the time of birth.

6.2 Newborn Transfers

If the newborn is transferred to another institution, the V30 series is not used.

6.3 Use of Category V29

- A. Assign a code from category V29, Observation and evaluation of newborns and infants for suspected conditions not found, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category V29 when the patient has identified signs or symptoms of a suspected problem; in such cases, code the sign or symptom.
- B. A V29 code is to be used as a secondary code after the V30, Outcome of delivery, code. It may also be assigned as a principal code for readmissions or encounters when the V30 code no longer applies. It is for use only for healthy newborns and infants for which no condition after study is found to be present.

6.4 Maternal Causes of Perinatal Morbidity

Codes from categories 760-763, Maternal causes of perinatal morbidity and mortality, are assigned only when the maternal condition has actually affected the fetus or newborn. The fact that the mother has an associated medical condition or experiences some complication of pregnancy, labor or delivery does not justify the routine assignment of codes from these categories to the newborn record.

6.5 Congenital Anomalies

Assign an appropriate code from categories 740-759, Congenital Anomalies, when

a specific abnormality is diagnosed for an infant. Such abnormalities may occur as a set of symptoms or multiple malformations. A code should be assigned for each presenting manifestation of the syndrome if the syndrome is not specifically indexed in ICD-9-CM.

6.6 Coding of Other (Additional) Diagnoses

- A. Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.
- B. Assign codes for conditions that have been specified by the physician as having implications for future health care needs.

NOTE: This guideline should not be used for adult patients.

- C. Assign a code for Newborn conditions originating in the perinatal period (categories 760-779), as well as complications arising during the current episode of care classified in other chapters, only if the diagnoses have been documented by the responsible physician at the time of transfer or discharge as having affected the fetus or newborn.
- D. Insignificant conditions or signs or symptoms that resolve without treatment are not coded.

6.7 Prematurity and Fetal Growth Retardation

Codes from categories 764 and 765 should not be assigned based solely on recorded birthweight or estimated gestational age, but upon the attending physician's clinical assessment of maturity of the infant.

NOTE: Since physicians may utilize different criteria in determining prematurity, do not code the diagnosis of prematurity unless the physician documents this condition.

7. SEPTICEMIA AND SEPTIC SHOCK

When the diagnosis of septicemia with shock or the diagnosis of general sepsis with septic shock is documented, code and list the septicemia first and report the septic shock code as a secondary condition. The septicemia code assignment should identify the type of bacteria if it is known.

Sepsis and septic shock associated with abortion, ectopic pregnancy, and molar pregnancy are classified to category codes in Chapter 11 (630-639).

Negative or inconclusive blood cultures do not preclude a diagnosis of septicemia in patients with clinical evidence of the condition.

8. TRAUMA

8.1 Coding for Multiple Injuries

When coding multiple injuries such as fracture of tibia and fibula, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-9-CM, but should not be assigned unless information for a more specific code is not available.

- A. The code for the most serious injury, as determined by the physician, is sequenced first.
- B. Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.
- C. When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) from categories 950-957, Injury to nerves and spinal cord, and/or 900-904, Injury to blood vessels. When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

8.2 Coding for Multiple Fractures

The principle of multiple coding of injuries should be followed in coding multiple fractures. Multiple fractures of specified sites are coded individually by site in accordance with both the provisions within categories 800-829 and the level of detail furnished by medical record content. Combination categories for multiple fractures are provided for use when there is insufficient detail in the medical record (such as trauma cases transferred to another hospital), when the reporting form limits the number of codes that can be used in reporting pertinent clinical data, or when there is insufficient specificity at the fourth-digit or fifth-digit level. More

specific guidelines are as follows:

- A. Multiple fractures of same limb classifiable to the same three-digit or four-digit category are coded to that category.
- B. Multiple unilateral or bilateral fractures of same bone(s) but classified to different fourth-digit subdivisions (bone part) within the same three-digit category are coded individually by site.
- C. Multiple fracture categories 819 and 828 classify bilateral fractures of both upper limbs (819) and both lower limbs (828), but without any detail at the fourth-digit level other than open and closed type of fractures.
- D. Multiple fractures are sequenced in accordance with the severity of the fracture and the physician should be asked to list the fracture diagnoses in the order of severity.

8.3 Current Burns and Encounters for Late Effects of Burns

Current burns (940-948) are classified by depth, extent and, if desired, by agent (E code). By depth burns are classified as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement).

- A. All burns are coded with the highest degree of burn sequenced first.
- B. Classify burns of the same local site (three-digit category level, (940-947) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.
- C. Non-healing burns are coded as acute burns. Necrosis of burned skin should be coded as a non-healed burn.
- D. Assign code 958.3, Posttraumatic wound infection, not elsewhere classified, as an additional code for any documented infected burn site.
- E. When coding multiple burns, assign separate codes for each burn site. Category 946 Burns of Multiple specified sites, should only be used if the location of the burns are not documented.

Category 949, Burn, unspecified, is extremely vague and should rarely be used.

- F. Assign codes from category 948, Burns classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category 948 as

additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category 948 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface. In assigning a code from category 948:

Fourth-digit codes are used to identify the percentage of total body surface involved in a burn (all degree).

Fifth-digits are assigned to identify the percentage of body surface involved in third-degree burn.

Fifth-digit zero (0) is assigned when less than 10 percent or when no body surface is involved in a third-degree burn.

Category 948 is based on the classic "rule of nines" in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Physicians may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults and patients who have large buttocks, thighs, or abdomen that involve burns.

- G. Encounters for the treatment of the late effects of burns (i.e., scars or joint contractures) should be coded to the residual condition (sequelae) followed by the appropriate late effect code (906.5-906.9). A late effect E code may also be used, if desired.
- H. When appropriate, both a sequelae with a late effect code, and a current burn code may be assigned on the same record.

8.4 Debridement of Wound, Infection, or Burn

- A. For coding purposes, excisional debridement, 86.22, is assigned only when the procedure is performed by a physician.
- B. For coding purposes, nonexcisional debridement performed by the physician or nonphysician health care professional is assigned to 86.28. Any "excisional" type procedure performed by a nonphysician is assigned to 86.28.

9. ADVERSE EFFECTS AND POISONING

The properties of certain drugs, medicinal and biological substances or combinations of such substances, may cause toxic reactions. The occurrence of drug toxicity is classified in ICD-9-CM as follows:

9.1 Adverse Effect

When the drug was correctly prescribed and properly administered, code the reaction plus the appropriate code from the E930-E949 series.

Adverse effects of therapeutic substances correctly prescribed and properly administered (toxicity, synergistic reaction, side effect, and idiosyncratic reaction) may be due to (1) differences among patients, such as age, sex, disease, and genetic factors, and (2) drug-related factors, such as type of drug, route of administration, duration of therapy, dosage, and bioavailability.

Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930-E949 series.

9.2 Poisoning

Poisoning when an error was made in drug prescription or in the administration of the drug by physician, nurse, patient, or other person, use the appropriate code from the 960-979 series. If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning (960-979 series). If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.

10. HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTIONS

10.1 Code only confirmed cases of HIV infection/illness.

This is an exception to guideline 1.8 which states "If the diagnosis documented at the time of discharge is qualified as 'probable,' 'suspected,' 'likely,' 'questionable,' 'possible,' or 'still to be ruled out,' code the condition as if it existed or was established..."

In this context, "confirmation" does not require documentation of positive

serology or culture for HIV; the physician's diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

10.2 Selection of HIV code

042 Human Immunodeficiency Virus [HIV] Disease

Patients with an HIV-related illness should be coded to 042, Human Immunodeficiency Virus [HIV] Disease.

V08 Asymptomatic Human Immunodeficiency Virus [HIV] Infection

Patients with physician-documented asymptomatic HIV infections who have never had an HIV-related illness should be coded to V08, Asymptomatic Human Immunodeficiency Virus [HIV] Infection.

795.71 Nonspecific Serologic Evidence of Human Immunodeficiency Virus [HIV]

Code 795.71, Nonspecific serologic evidence of human immunodeficiency virus [HIV], should be used for patients (including infants) with inconclusive HIV test results.

10.3 Previously diagnosed HIV-related illness

Patients with any known prior diagnosis of an HIV-related illness should be coded to 042. Once a patient had developed an HIV-related illness, the patient should always be assigned code 042 on every subsequent admission. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08.

10.4 Sequencing

The sequencing of diagnoses for patients with HIV-related illnesses follows guideline 2 for selection of principal diagnosis. That is, the circumstances of admission govern the selection of principal diagnosis, "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Patients who are admitted for an HIV-related illness should be assigned a minimum of two codes: first assign code 042 to identify the HIV disease and then sequence additional codes to identify the other diagnoses. If a patient is admitted for an HIV-related condition, the principal diagnosis should be 042, followed by additional diagnosis codes for all reported HIV-related conditions.

If a patient with HIV disease is admitted for an unrelated condition (such as a

traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be 042 followed by additional diagnosis codes for all reported HIV-related conditions.

Whether the patient is newly diagnosed or has had previous admissions for HIV conditions (or has expired) is irrelevant to the sequencing decision.

10.5 HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis of 647.6X, Other specified infectious and parasitic diseases in the mother classifiable elsewhere, but complicating the pregnancy, childbirth or the puerperium, followed by 042 and the code(s) for the HIV-related illness(es). This is an exception to the sequencing rule found in 10.4 above.

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of 647.6X and V08.

10.6 Asymptomatic HIV Infection

V08 Asymptomatic human immunodeficiency virus [HIV] infection, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use 042 in these cases.

10.7 Inconclusive Laboratory Test for HIV

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness may be assigned code 795.71. Inconclusive serologic test for Human Immunodeficiency Virus [HIV]

10.8 Testing for HIV

If the patient is asymptomatic but wishes to know his/her HIV status, use code V73.89, Screening for other specified viral disease. Use code V69.8, Other problems related to lifestyle, as a secondary code if an asymptomatic patient is in a known high-risk group for HIV. Should a patient with signs or symptoms or illness, or a confirmed HIV related diagnosis be tested for HIV code the signs and symptoms or the diagnosis. An additional counseling code V65.44 may be used if counseling is provided during the encounter for the test.

When the patient returns to be informed of his/her HIV test results use code

V65.44, HIV counseling, if the results of the test are negative. If the results are positive but the patient is asymptomatic use code V08, Asymptomatic HIV infection. If the results are positive and the patient is symptomatic use code 042, HIV infection, with codes for the HIV related symptoms or diagnosis. The HIV counseling code may also be used if counseling is provided for patients with positive test results.

11. GUIDELINES FOR CODING EXTERNAL CAUSES OF INJURIES, POISONINGS AND ADVERSE EFFECTS OF DRUGS (E Codes)

Introduction: These guidelines are provided for those who are currently collecting E codes in order that there will be standardization in the process. If your institution plans to begin collecting E codes, these guidelines are to be applied. The use of E codes are supplemental to the application of basic ICD-9-CM codes. E codes are never to be recorded as principal diagnosis (first listed in the outpatient setting) and are not required for reporting to the Health Care Financing Administration.

Injuries are a major cause of mortality, morbidity and disability. In the United States, the care of patients who suffer intentional and unintentional injuries and poisonings contributes significantly to the increase in medical care costs. External causes of injury and poisoning codes (E codes) are intended to provide data for injury research and evaluation of injury prevention strategies. E codes capture how the injury or poisoning happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), and the place where the event occurred. Some major categories of E codes include:

- transport accidents
- poisoning and adverse effects of drugs, medicinal substances and biologicals
- accidental falls
- accidents caused by fire and flames
- accidents due to natural and environmental factors
- late effects of accidents, assaults or self injury
- assaults or purposely inflicted injury
- suicide or self inflicted injury

These guidelines apply for the coding and collection of E code from records in hospitals, outpatient clinics, emergency departments, other ambulatory care settings and physician offices except when other specific guidelines apply. (See Reporting Diagnostic Guidelines for Hospital-based Outpatient Services/Reporting Requirements for Physician Billing.)

11.1 GENERAL E CODE CODING GUIDELINES

- A. An E code may be used with any code in the range of 001-V82.9 which indicates an injury, poisoning, or adverse effect due to an external cause.

- B. Assign the appropriate E-code for all initial treatments of an injury, poisoning, or adverse effect of drugs.
- C. Use a late effect E code for subsequent visits when a late effect of the initial injury or poisoning is being treated. There is no late effect E code for adverse effects of drugs.
- D. Use the full range of E codes to completely describe the cause, the intent and the place of occurrence, if applicable, for all injuries, poisonings, and adverse effects of drugs.
- E. Assign as many E codes as necessary to fully explain each cause. If only one E code can be recorded, assign the E code most related to the principal diagnosis.
- F. The selection of the appropriate E code is guided by the Index to External Causes which is located after the alphabetical index to diseases and by Inclusion and Exclusion notes in the Tabular List.
- G. An E code can never be a principal (first listed) diagnosis.

11.2 PLACE OF OCCURRENCE GUIDELINE

Use an additional code from category E849 to indicate the Place of Occurrence for injuries and poisonings. The Place of Occurrence describes the place where the event occurred and not the patient's activity at the time of the event.

Do not use E849.9 if the place of occurrence is not stated.

11.3 POISONINGS AND ADVERSE EFFECTS OF DRUGS, MEDICINAL AND BIOLOGICAL SUBSTANCES GUIDELINES

- A. Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.
- B. Use as many codes as necessary to describe completely all drugs, medicinal or biological substances.
- C. If the same E code would describe the causative agent for more than one adverse reaction, assign the code only once.
- D. If two or more drugs, medicinal or biological substances are reported, code each individually unless the combination code is listed in the Table of Drugs and Chemicals. In that case, assign the E code for the combination.
- E. When a reaction results from the interaction of a drug(s) and alcohol, use

poisoning codes and E codes for both.

- F. If the reporting format limits the number of E codes that can be used in reporting clinical data, code the one most related to the principal diagnosis. Include at least one from each category (cause, intent, place) if possible.

If there are different fourth digit codes in the same three digit category, use the code for "Other specified" of that category. If there is no "Other specified" code in that category, use the appropriate "Unspecified" code in that category.

If the codes are in different three digit categories, assign the appropriate E code for other multiple drugs and medicinal substances.

11.4 MULTIPLE CAUSE E CODE CODING GUIDELINES

If two or more events cause separate injuries, an E code should be assigned for each cause. The first listed E code will be selected in the following order:

E codes for child and adult abuse take priority over all other E codes- see Child and Adult abuse guidelines

E codes for cataclysmic events take priority over all other e codes except child and adult abuse

E codes for transport accidents take priority over all other e codes except cataclysmic events and child and adult abuse

The first list E code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

11.5 CHILD AND ADULT ABUSE GUIDELINE

- A. When the cause of an injury or neglect is intentional child or adult abuse, the first listed e code should be assigned from categories E960-E968, Homicide and injury purposely inflicted by other persons, (except category E967). An E code from category E967, Child and adult battering and other maltreatment, should be added as an additional code to identify the perpetrator, if known.

- B. In cases of neglect when the intent is determined to be accidental E code E904.0, Abandonment or neglect of infant and helpless person, should be the first listed E code.

11.6 UNKNOWN OR SUSPECTED INTENT GUIDELINE

- A. If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is unknown or unspecified, code the intent as undetermined E980-E989.
- B. If the intent (accident, self-harm, assault) of the cause of an injury or poisoning is questionable, probable or suspected, code the intent as undetermined E980-E989.

11.7 UNDETERMINED CAUSE

When the intent of an injury or poisoning is known, but the cause is unknown, use codes: E928.9, Unspecified accident, E958.9, Suicide and self-inflicted injury by unspecified means, and E968.9, Assault by unspecified means.

These E codes should rarely be used as the documentation in the medical record, in both the inpatient and outpatient settings, should normally provide sufficient detail to determine the cause of the injury.

11.8 LATE EFFECTS OF EXTERNAL CAUSE GUIDELINES

- A. Late effect E codes exist for injuries and poisonings but not for adverse effects of drugs, misadventures and surgical complications.
- B. A late effect E code (E929, E959, E969, E977, E989, or E999) should be used with any report of a late effect or sequela resulting from a previous injury or poisoning (905-909).
- C. A late effect E code should never be used with a related current nature of injury code.

11.9 MISADVENTURES AND COMPLICATIONS OF CARE GUIDELINES

- A. Assign a code in the range of E870-E876 if misadventures are stated by the physician.
- B. Assign a code in the range of E878-E879 if the physician attributes an abnormal reaction or later complication to a surgical or medical procedure, but does not mention misadventure at the time of the procedure as the cause of the reaction.

12 DIAGNOSTIC CODING AND REPORTING GUIDELINES FOR OUTPATIENT SERVICES (HOSPITAL-BASED AND PHYSICIAN OFFICE)

Revised October 1, 1995

Introduction

These revised coding guidelines for outpatient diagnoses have been approved for use by hospitals/physicians in coding and reporting hospital-based outpatient services and physician office visits. These guidelines replace the official guidelines on the October 1, 1994 CD-ROM.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-9-CM Tabular List (code numbers and titles), can be found in the section at the beginning of the ICD-9-CM on "Conventions Used in the Tabular List." Information about the correct sequence to use in finding a code is described in the Introduction to the Alphabetic Index of ICD-9-CM.

The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Coding guidelines for outpatient and physician reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, general hospitals.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

BASIC CODING GUIDELINES FOR OUTPATIENT SERVICES

- A. The appropriate code or codes from 001.0 through V82.9 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

- B. For accurate reporting of ICD-9-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-9-CM codes to describe all of these.
- C. The selection of codes 001.0 through 999.9 will frequently be used to describe the reason for the encounter. These codes are from the section of ICD-9-CM for the classification of diseases and injuries (e.g. infectious and parasitic diseases; neoplasms; symptoms, signs, and ill-defined conditions, etc.).
- D. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been diagnosed (confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 - 799.9) contain many, but not all codes for symptoms.
- E. ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Supplementary Classification of factors Influencing Health Status and Contact with Health Services (V01.0-V82.9) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.
- F. ICD-9-CM is composed of codes with either 3, 4, or 5 digits. Codes with 3 digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits which provide greater specificity.

A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.

- G. List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions.
- H. Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," or working diagnosis. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This is contrary to the coding practices used by hospitals and medical record departments for coding the diagnosis of hospital inpatients.

- I. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- J. Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10- V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- K. For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.
- L. For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that patients receiving chemotherapy, radiation therapy, or rehabilitation, the appropriate V code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

- N. For patient's receiving preoperative evaluations only, sequence a code from category V72.8, Other specified examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.
- O. For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.